

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Lehigh LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1718 Spring Creek Road MacUnjie, PA 18062	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on facility policy review, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for two of 24 sampled residents. (Residents 63 and 76) Findings include: Review of facility policy entitled, Resident Self-Administration of Medication, last reviewed June 1, 2025, revealed that a resident may only self-administer medications after the facility's interdisciplinary team had determined which medications may be self-administered safely. The resident's preference would be documented in the clinical record. The results of the interdisciplinary team assessment would be recorded in the Self Administration of Medication Assessment. Bedside storage would be permitted only when it did not present a risk to confused residents who wandered into other residents' rooms or to confused roommates of the resident who self-administered medication and the manner of storage prevented access by other residents. Clinical record review revealed that Resident 63 had diagnoses that included heart failure, diabetes, depression, and mild cognitive impairment. Review of the Minimum Data Set (MDS) assessment, dated May 19, 2025, revealed that Resident 63's cognitive ability was intact. Observation on August 19, 2025, between 10:36 a.m. and 11:15 a. m., revealed a medicine cup containing 11 unidentified pills and a bottle of Fluticasone nasal spray (a medication used to treat symptoms caused by allergies) unsecured on the bedside table in Resident 63's room. An interview with RN1 on August 19, 2025, at 11:30 a.m., revealed that when RN1 brought Resident 63 his morning medications he was eating breakfast, and he preferred to take them after breakfast. RN1 confirmed she left the medications on the resident's bedside table for him to take later. Observation on August 20, 2025, at 9:40 a.m. revealed a bottle of Fluticasone nasal spray and a bottle of multivitamin gummies unsecured on the bedside table in Resident 63's room. In an interview on August 20, 2025, at 9:40 a.m., Resident 63 stated that he self-administered the Fluticasone as needed and the multivitamin gummies daily. There was no documentation to indicate that the facility had assessed Resident 63 for the ability to self-administer the Fluticasone nasal spray and multivitamin gummies. The medications were not secured in his room. Clinical record review revealed that Resident 76 had diagnoses that included high blood pressure and high levels of fat in the blood. Review of the MDS assessment, dated July 31, 2025, revealed that Resident 76's cognitive ability was intact. Observations on August 19, 2025, at 12:45 p.m. and August 20, 2025, at 12:00 p.m. revealed one bottle of Tylenol 650 mg tablets and a bottle of cannabidiol (CBD) gummies unsecured in the third drawer of the dresser in Resident 76's room. In an interview on August 20, 2025, at 12:00 p.m., Resident 76 stated that he self-administered two Tylenol tablets daily and he does not use the CBD gummies. There was no documentation to indicate that the facility had assessed Resident 76 for the ability to self-administer the Fluticasone nasal spray and gummy vitamins. The medications were not secured in his room. In an interview on August 21, 2025, at 9:00 a.m., the Nursing Home Administrator confirmed that Residents 63 and 76 were not assessed to self-administer the medications as per the facility policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395939
		If continuation sheet Page 1 of 5

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for one of 24 sampled residents. (Resident 118) Findings include: Clinical record review revealed that Resident 118 had diagnoses that included multiple sclerosis (a disease that affects the brain and spinal cord) and diabetes. Review of Resident 118's MDS assessment dated [DATE], indicated Resident 118 was on dialysis. There was no documentation in the clinical record that indicated Resident 118 was on dialysis. In an interview on August 21, 2025, at 9:07 a.m., the Director of Nursing confirmed that the MDS assessment had been inaccurately coded, and that Resident 118 was not on dialysis at that time. CFR: 483.25 Accuracy of Assessments Previously cited 7/12/2024.28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that appropriate assistance with grooming and personal hygiene was provided to one of two sampled residents who required assistance from staff to complete activities of daily living(ADL's). (Resident 10)Findings include:Clinical record review revealed that Resident 10 had diagnoses that included acute respiratory failure, chronic obstructive pulmonary disease and disorder of the brain. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and dependent on staff for ADL's. A review of the care plan revealed that he had an ADL self care deficit. Observation on August 19, 2025, at 11:30 a.m., 12:00 p.m., 12:30 p.m., and 1:30 p.m., revealed that the resident was lying in bed and his finger nails were dirty. He was not dressed and had not received assistance from staff with his ADL care. Observation on August 20, 2025, at 8:37 a.m., 9:14 a.m., 10:05 a.m., 11:00 a.m., and 12:30 p.m., revealed that the resident was lying in bed and his nails were still dirty. In an interview on August 21, 2025, at 12:05 p.m., the Director of Nursing stated that the resident was dependent on staff for all of his ADL care. 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for one of 24 sampled residents. (Resident 11) Findings include: Clinical record review revealed that Resident 11 had diagnoses that included hypertension (high blood pressure) and heart failure. On June 20, 2025, a physician ordered that staff administer a medication (Propranolol HCl) twice a day to treat the resident's hypertension. Staff was not to give the medication if the resident had a systolic blood pressure (the first measurement of blood pressure when the heart beats, and the pressure is at its highest) of less than 110 millimeters of mercury (mm/Hg) and a heart rate less than 55. A review of Resident 11's Medication Administration Record revealed that staff administered the medication when the resident's systolic blood pressure was under 110 mm/Hg on three occasions in July 2025, and three occasions in August 2025. In an interview conducted on August 21, 2025, at 11:45 a.m., the Director of Nursing confirmed that the medication was administered outside of established parameters for Resident 11. CFR: 483.25 Quality of Care Previously cited 7/12/2024. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide necessary treatment and services to promote healing and to prevent new pressure sores from developing for one of two sampled residents who had pressure sores. (Resident 10) Findings include: Clinical record review revealed that Resident 10 had diagnoses that included acute respiratory failure, chronic obstructive pulmonary disease and disorder of the brain. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert, dependent on staff for activities of daily living (ADL's), and was at risk for developing pressure sores. A review of the care plan revealed that the resident had a potential for impairment to skin due to incontinence. On June 7, 2025, an intervention was added to the care plan for staff to elevate both of his heels off of the bed with pillows. On July 21, 2025, an intervention was added for staff to apply Medix boots (pressure relieving boots) at all times. There was also a current physician order for staff to apply the Medix boots at all times. Review of a nursing skin and wound note dated August 19, 2025, indicated that the resident had a pressure sore on his right heel. The recommended preventative measure was for staff to float his heels off of the bed with the use of the heel boots. Observations on August 19, 2025, at 11:30 a.m., 12:00 p.m., 1:30 p.m., and 2:22 p.m., revealed that the resident was observed lying in bed without the Medix boots in place. He had one sock on and one sock off and both of his heels were lying directly on the bed. Observations on August 20, 2025, at 8:37 a.m., 9:14 a.m., 10:05 a.m., 11:00 a.m., and 12:30 p.m., the resident was again observed lying in bed without the Medix boots in place. He had socks on and both of his heels were lying directly on the bed. On both days, during all of the observations, the Medix boots were observed on the floor against the wall in the corner of his room. In an interview on August 21, 2025, at 11:15 a.m., the Director of Nursing confirmed that the Medix boots were a pressure relieving device and that the Medix boots were to be applied to the resident's feet at all times. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		